

June 30, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0970-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified neurologist. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 38 year-old female who sustained a work related injury on ___. The patient reported that while at work she was attempting to lift a resident into a tub when both the patient and the resident fell to the ground. The patient reported that she experienced immediate pain in her right side. The patient has undergone X-Rays, CT scans and MRI's of the injured area. The diagnoses for this patient have included rule out rupture/herniation cervical disc, rule out rupture/herniation lumbar disc, radiculitis-cervical and muscle spasm. The patient has been treated with biofeedback, individual psychotherapy, passive and active physical therapy, rehabilitation, nerve blocks, other passive modalities and medications.

Requested Services

Chronic Pain Management Program times 30 sessions.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 38 year-old female who sustained a work related injury to her low back on ___. The ___ physician reviewer also noted that the diagnoses for this patient included cervical disc disease, lumbar disc disease, radiculitis-cervical and muscle spasm. The ___ physician reviewer further noted that treatment for this patient's condition has included multiple therapies including analgesic medications, active and passive physical therapy, biofeedback, individual psychotherapy, chiropractic manipulation and nerve blocks. The ___ physician reviewer indicated that despite treatment, this patient continues to complain of pain. The ___ physician reviewer also indicated that this patient has undergone a psychological evaluation, which concluded that this patient has an atypical depression and a psychological disorder associated with a medical condition. The ___ physician reviewer noted that this patient's treating physician and an independent physician evaluator both feel she has reached maximal medical improvement from her injuries. However, the ___ physician reviewer explained that both physicians concur that this patient's depressive disorder requires treatment. The ___ physician reviewer also explained that there is not documentation provided that indicated this patient has tried and failed alternative medical therapies with additional medications (NSAIDS Cox II inhibitors, anticonvulsants or tricyclic antidepressants), in conjunction with medical and/or psychotherapy for her depression. The ___ physician reviewer further explained that treatment of the depressive disorder should be undertaken prior to consideration for a chronic pain management program. Therefore, the ___ physician consultant concluded that the requested chronic pain management program times 30 sessions is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of June 2003.